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Subcommittee on Health

# IPAB: Its Impacts on Medicare, its Beneficiaries, and Healthcare Providers

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*The views expressed in this testimony are those of the author alone and do not necessarily represent  
those of the American Enterprise Institute.*

## **Introduction**

Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify today before the House Committee on Ways and Means, Subcommittee on Health.

The Independent Payment Advisory Board (IPAB) is premised on a belief that decisions about how we price the services offered by Medicare are simply too contentious to be adequately addressed by our political system. Politics, it's argued, inevitably stymie our ability to make hard decisions to cut prices and reduce coverage of services. As a result, it becomes impossible to shrink the growth in spending. So IPAB was designed to remove the supervision of the Medicare program, and Congress, from these choices.<sup>i</sup>

But judgments about how we price medical services, and how those prices affect access to care, are precisely the kinds of consequential choices that should be subject to close public scrutiny. We need to have an open, rigorous, and transparent process for making these decisions. We need to actively engage Medicare's stakeholders in these deliberations, to make sure that these policies don't create unintended consequences for beneficiaries. IPAB, instead, aims to freeze stakeholders out of this process.

Changes to the way Medicare covers and pays for medical care affect too many people in significant ways to be made behind the closed doors of an insulated committee that's not accountable to beneficiaries, providers, or even to Congress. How Medicare prices products and services have sweeping implications across the entire private marketplace precisely because of the way private health plans emulate Medicare's billing schedules.

These decisions are some of the most important policy choices that we make inside our healthcare system. There are too many unpredictable consequences from these choices to let them be made in an open process that isn't subject to close public scrutiny.

## **Shortcomings in IPAB's Construction**

Because of the substantial flaws in IPAB's mission, and the way that the board is constructed, it's activities are going to inevitably affect patients' access to care, despite Congress' intentions to make sure that IPAB couldn't limit the "benefits".<sup>ii</sup>

IPAB was purposely designed to take decisions about how to cut Medicare's spending on products and services out of any public debate. The implementation of IPAB's decisions is not subject to review by the Medicare program, and only tacitly subject to approval by Congress. There is no requirement for advance notice and solicitation of public comment. The board's decisions pre-empt the entire administrative and legislative process.

Patients have no way to appeal its decisions. Affected sponsors can't sue IPAB for recourse. Yet the board has enormous power. It can re-write laws already enacted by Congress with little meaningful opportunity for Congress to intervene.

IPAB's recommendations will be fast tracked through Congress, in a way that provides for only a veneer of Congressional review and consent. This was probably a nod to Constitutional requirements for a separation of powers between the Executive and legislative branches rather than a desire for genuine Congressional input.

For practical purposes, IPAB has been given the authority to legislate. Moreover, there's a belief that if IPAB fails to fulfill its mandate, these decisions will default to Congress. Actually, under the law, they default to the Secretary of Health and Human Services.

The cumulative effect of the rules for appointing members to IPAB will almost guarantee that most of its outside members hail from the insular ranks of academia.

In short, every aspect of this board was designed to remove significant decisions about Medicare cuts from public scrutiny and open debate. This was the intention. But it's a flawed premise to believe that we will get a better result by sidestepping an open, vigorous policy debate about how we price and cover services under Medicare.

Most significantly, IPAB is unlikely to take steps that actually improve the quality of medical care and the delivery of services under Medicare.

That's because IPAB does not have any practical alternative to simply squeezing prices in the Medicare program. Owing to the way it is set up, IPAB is statutorily required to achieve its savings in the short term. This will mean IPAB can do little more than manipulate Medicare's current price schedules and its coding process.

The problem we have in Medicare is not a short-term problem that can be fixed with price squeezes. We have already been trying and failing at that for the last 45 years. It's a problem with the existing price controls that erode healthcare productivity and Medicare's outdated fee-for-service payment system that leads to inefficient medical care and inadequate support for better, more innovative ways of delivering medical care.

IPAB can't pursue longer-term reforms to change incentives and behavior. These ideas (for example, aligning reimbursement with value and quality, or expanding cost-sharing) don't generate much savings in the short run, since their premised on long-term changes in how efficiently doctors and patients use medical services.

These proposals will not produce the kind of immediate savings that IPAB needs to achieve in the narrow budget windows that'll be its focus. Yet these are precisely the kinds of reforms that Congress has aimed to pursue on a bipartisan basis. By "doubling down" on the existing practice of simply whacking existing price schedules in order to slow spending – with no meaningful eye to how these changes impact long-term

incentives -- IPAB will put more systemic payment reforms further out of reach. IPAB, in short, will be working at cross-purposes to Congress' broader reform goals.

IPAB's need to focus on short-run manipulation of price schedules and coding procedures is evidenced by the fact that longer-term payment reforms don't "score" as saving money by the Congressional Budget Office or the Medicare Actuary (who has to sign off on IPAB's recommendations). The Medicare Actuary scored most of the Affordable Care Act's provisions based on quality improvement as getting little to no savings over the full decade, even though we all remain hopeful that these provisions will lead to genuine efficiencies. All of these ideas for broader payment reform also rely on changes in payment to providers, especially hospitals. IPAB can't do these kinds of structural reforms if these constituencies remain off limits until 2019.

Almost by default, IPAB will have to settle for manipulating existing price schedules -- either reducing current payment rates, tweaking codes, or importing price schedules from one market for products and services into new areas. Moreover, because IPAB had its purview narrowly targeted to specific slices of the industry, to achieve the targeted saving, IPAB may be forced to implement unusually deep cuts to the limited terrain where it can operate. These deep cuts could forestall access altogether to certain products and services. There's evidence that higher payments expand access to physicians.<sup>iii</sup> The opposite is also true. The Medicare Actuary estimates that Medicare rates will eventually be driven below Medicaid rates under the current budget assumptions.

Additionally, just because IPAB is exempt from limiting "benefits" doesn't mean it can't limit coverage in ways that reduce patients' access to medical care. IPAB could, in practice, still create policies that affect how particular services are covered by benefits. It seems clear that IPAB will have the power to confer the Centers for Medicare and Medicaid Services with new authorities that will enable the Medicare agency to make more granular decisions about what medical products and services it chooses to cover.

Rather than making the tough clinical judgments themselves about the relative value of individual products and services, IPAB would grant CMS authority to exert more control over benefit design, to rely on judgment of the agency's largely thin clinical staff about the coverage it will provide for competing treatments. This could have significant implications. While the new law bars IPAB from reducing the coverage of specific items, there is nothing barring IPAB from giving CMS authorities to engage in similar activities.

If Congress intended CMS to have more deliberate authorities to make decisions about what services should and shouldn't be covered by Medicare, I think many here today, on this Committee, would want the opportunity to weigh those decisions and not have them conferred by a remote agency that's removed from public oversight. These kinds of tough choices get to the very heart of what kind of benefit Medicare will ultimately become, and whether it will remain adequate medical benefit or see its practical value eroded.

For those who believe that IPAB will take a cautious, go-slow approach, the exact opposite may be true. That's because IPAB may only get a few chances during their

tenure to implement changes. When these windows open up, their institutional prejudice will be to overshoot, not undershoot. Under IPAB's charter, it only gets to make policy when the rate of Medicare growth is expected to exceed CPI by a certain measure. This means IPAB may only have the chance to legislate once every several years.

Some of its members will undoubtedly worry they may not get more than one chance to push favored ideas. So they'll try and get their proposals implemented when they have the opening. Similarly, members may decide that it's politically easier to issue proposals once every several years rather than come up with a new set of policies annually.

### **Impact of IPAB's Actions**

Medicare is no ordinary payer. Its decisions should be subject to close scrutiny precisely because of their wide-ranging impact. Yet IPAB's entire scheme is far less transparent, rigorous, and open to challenge than the average private health plan.

This will have implications for patients and providers. It will also have significant implications for those developing new medical technologies. It will make that process more uncertain, more costly, and less attractive to new investment.

Can you imagine a private health plan making retrospective decisions about coverage and payment after it had contracted with providers and beneficiaries, and then proclaiming itself exempt from any appeals by patients, judicial review by beneficiaries or providers, and relieved of any serious political scrutiny? This is effectively how IPAB will operate, not by its own fidelity but by legislative design, according to its Congressional mandate. Congress has created the very constructs that it derides, and penalizes, when private companies undertake similar practices that deny consumers a chance for petition.

Medicare must continue to implement reforms to align its coverage and payment policies with the value being delivered to beneficiaries. The only consistent way is to develop policies that enable these decisions to be made in a de-centralized fashion, based on the actual demand from consumers and providers. We can't develop these kinds of long-term reforms by lodging these judgments into the hands of an increasingly narrow and insulated band of appointed "experts" who are beholden to short-term budget goals.

Congress needs to focus on real ways to get longer-term savings, like premium support, modernizing benefits in traditional Medicare, and paying for better outcomes. IPAB makes it even harder to do all these things. The activities of IPAB will only serve to put more meaningful, global payment reforms further out of reach.

If Congress believes that the political process is incapable of making enduring decisions about the payment of medical benefits, then this is an argument for limiting the government role in making these kinds of judgments in the first place. It's not a call for creating an insular panel, exempt from public scrutiny; to take on decisions that other Federal agencies have failed to adequately discharge. Choices about how we price and

cover medical benefits under Medicare are simply too important for Americans to remove from public scrutiny and from the close supervision of Congress.

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<sup>i</sup> The Affordable Care Act prohibits IPAB from making any recommendations prior to December 31, 2018 that would “reduce payment rates” on items and services furnished by a Medicare provider that is scheduled “to receive a reduction in the inflationary payment updates...in excess of a reduction due to productivity” in a year in which the recommendation is to take effect. This was meant to exempt hospitals from being targeted by IPAB prior to 2019.

<sup>ii</sup> The law states: The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

<sup>iii</sup> Chapin White. A Comparison of Two Approaches to Increasing Access to Care: Expanding Coverage versus Increasing Physician Fees. February 2, 2012. DOI: 10.1111/j.1475-6773.2011.01378.x